

**Oasis Colon Hydrotherapy Client Information & Medical History**

**PERSONAL HISTORY:**

**Client Name: Phone Number: Today’s Date:**

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**Home Address: City: State: Zipcode:**

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| --- | --- | --- | --- |

**Date of Birth: Age: Occupation:**

|  |  |  |
| --- | --- | --- |

**Height: Weight: Female: Male: Marital Status:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |

**Emergency Contact Name: Phone Number:**

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**How did you find out about Oasis Colon Hydrotherapy:**

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**MEDICAL HISTORY:**

**Are you currently under the care of a physician? (circle one) If yes, what for?**

| **Y or N** |  |
| --- | --- |

**Do you have a prescription for this visit? (circle one) If yes, do we have a copy on file?**

| **Y or N** | **Y or N** |
| --- | --- |

**Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you?**

| **Y or N** | **If yes, name and type of doctor:** | **Reason:** | **Referral****Date::** |
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**Do you have any of the following conditions? Please circle all that apply:**

| **Abdominal Hernia****Acute Liver Failure****Cardiac Conditions****Crohn’s Disease****Fissures/Fistulas****Lupus****IBS/ Bloating****Parasites** | **Constipation****Abdominal Surgery****Anemia****Colitis****Hemorrhaging****Pregnant****AIDS****Blood in stool** | **Diarrhea****Rectal Bleeding****Abnormal Distension****Aneurysm****Dialysis patient****Hemorrhoidectomy****Rectal/Colon surgery****Diverticulitis** | **Infectious Disease****Hepatitis B or C****Cancer of the Colon****Intestinal Perforations****Renal Insufficiencies****Bladder Infection****Itching Anus****Hemorrhoids**  |
| --- | --- | --- | --- |

**Do you have any communicable diseases?**

| **Y or N** | **If yes, explain:** |
| --- | --- |

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**Do you have any other health problems or medical conditions?**

| **Y or N** | **If yes, please list:** |
| --- | --- |

**MEDICATIONS & SUPPLEMENTS:**

**List all you now take regularly including over the counter meds:**

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| **Do you take digestive aids/laxatives? Y or N** |  **If yes, describe:** |
| --- | --- |

| **Are you on any Steroids?** **Y or N** |  **If yes, injections or oral?**  |
| --- | --- |

| **Are you on any blood thinners? Y or N** | **Are you on any diuretics? Y or N** |
| --- | --- |

**When was the last time you were on an antibiotic and why?**

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**ADDITIONAL INFORMATION:**

| **Describe your regular routine for exercise:** |
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**On a scale of 1 to 10 where, 1 = can’t get of bed and 10 = optimal energy. Rate your normal energy level:\_\_\_\_**

**How many servings of vegetables do you eat per day?\_\_\_\_ How many servings of fruit do you eat daily?\_\_\_\_\_**

**How much water do you drink daily? \_\_\_\_\_\_\_\_\_ How much dairy do you eat per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How much meat do you eat per day or week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **Do you smoke?****Y or N**  | **If yes, how much daily and for how long?** |
| --- | --- |

| **Do you drink alcohol?****Y or N**  | **If yes, how much daily and for how long?** |
| --- | --- |

**How often do you have a bowel movement? Please share how many daily and if you skip days.**

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**Color and consistency of bowel movements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What do you hope to achieve from this Colon Hydrotherapy session?**

|  |
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| **Do you have specific concerns?**  **Y or N**  | **If yes, explain:** |
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**My signature below indicates that I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.**

| **Client Name(Printed clearly):** | **Client Signature:**  | **Date:** |
| --- | --- | --- |

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